North Carolina Department of Health and Human Services
Division of Medical Assistance - Provider Services
2501 Mail Services Center - Raleigh NC 27699-2501
Telephone (919) 855-4050
http://www.dhhs.state.nc.us/dma/

COMMUNITY INTERVENTION SERVICES (CIS) AGENCY RE-ENROLLMENT ADDENDUM INSTRUCTIONS

Dear CIS Provider,

Thank you for your interest in re-enrolling as a CIS provider with the NC Medicaid Program. Licensed providers are required to submit the following annually:

1. **A completed Community Intervention Services (CIS) Agency Provider Re-enrollment Addendum**. The original Addendum with original signature and required attachments must be submitted together. Incomplete Addendum packets will be returned to the provider by mail for completion. **Please staple each packet to secure all of the pages and documents together**. Faxes will not be accepted. Correction fluid, highlighter, strikethroughs and any alterations to the addendum are not acceptable.
   The provider name on the addendum must exactly match the provider name on your original Medicaid Participation Agreement.
   Write your Medicaid CIS Provider Core Medicaid Number in the upper right corner of each page of the Addendum and each attached document.

2. **A copy of your new Notification of Endorsement Action (NEA) letter issued by your Local Management Entity (LME).** If you are a licensed provider, the NEA letter must reference the name of the facility and the physical address of the facility as reflected on your facility license. Licensed providers include: Professional Treatment Facility Based Crisis Programs, Partial Hospital, Ambulatory Detox, Non-Hospital Detox, all Substance Abuse providers, Child and Adolescent Day Treatment, Psychosocial Rehab and Opioid Treatment. You must write your CIS Core Medicaid provider number in the upper right corner of the NEA.

3. **A copy of your renewed facility license (if applicable) issued by The Division of Health Service Regulation (DHSR) formerly known as The Division of Facility Services (DFS).** You must write your CIS Core Medicaid provider number in the upper right corner of the license.

4. **If you desire to receive acknowledgement that your documents have been received at DMA**, you must complete the attached acknowledgement card and submit it with your addendum packet. It will be helpful if you submit your packet with this page on top.

MAIL THE ADDENDUM PACKET TO:
DMA Provider Services - 06
Attn: CIS Provider Enrollment
2501 Mail Services Center
Raleigh, NC 27699-2501

You will be notified by mail once your CIS Re-enrollment Addendum packet has been approved and your Medicaid participation has been renewed. Billing information and medical coverage polices are available on DMA's website at http://www.dhhs.state.nc.us/dma/prov.htm. Thank you again for your interest, if you have any questions or need additional information, please feel free to contact your CIS Provider Enrollment Specialist at (919) 855-4060.

INSTRUCTIONS FOR APPLICATION ACKNOWLEDGEMENT CARD

Please fill in the information below.
This is our method of acknowledging receipt of your application.

PLACE A STAMP ON THE ACKNOWLEDGEMENT CARD TO ENSURE DELIVERY BY THE POST OFFICE.

Provider Services
DHHS/DMA
2501 Mail Services Center
Raleigh NC 27699-2501

PLACE STAMP HERE. POST OFFICE WILL NOT DELIVER WITHOUT PROPER POSTAGE.

_____
Name

_____
Address

_____
City State Zip Code

Write your CIS core Medicaid provider number here:

83 ☐ ☐ ☐ ☐ ☐

CIS Re-enrollment
Application Acknowledgement Card

Dear Provider:

We have received your application for re-enrollment in the NC Medicaid Program. Our standard processing time is approximately 6-8 weeks from the date of receipt of a complete and correct packet. Incorrect or incomplete packets will be returned to you.

Return of this acknowledgement card certifies that DMA has received your CIS re-enrollment packet. Please allow for our processing time before making status inquiry calls, as this may delay the processing time.

Thank you again for your participation in the NC Medicaid Program.

Sincerely,

DMA Provider Services

Date of Receipt

CIS Core Medicaid Provider # _____

North Carolina Department of Health and Human Services
Division of Medical Assistance
Provider Services

COMMUNITY INTERVENTION SERVICES (CIS) AGENCY RE-ENROLLMENT ADDENDUM

Use this re-enrollment addendum to re-enroll the services for which you have already been assigned a Medicaid provider number. Do not use this form to enroll new services. For new services, please complete the appropriate enrollment application located at http://www.ncdhhs.gov/dma/provenroll.htm.

ALL FIELDS ARE REQUIRED. INCOMPLETE ADDENDUMS WILL BE RETURNED TO THE PROVIDER, WHICH MAY RESULT IN DELAYED RENEWAL AND DENIED CLAIMS

Type or Print (legibly) All Information in Black Ink

1. **Current CIS Provider Core Number: 83** ☐☐☐☐☐

Indicate the Community Intervention Services for which your business/agency is currently enrolled:

- ☐ Ambulatory Detox
- ☐ Assertive Community Treatment Team (ACTT)
- ☐ Child and Adolescent Day Treatment (CADT)
- ☐ Community Based Rehabilitative Service (CBRS) Early Intervention
- ☐ Community Support Services
- ☐ Detoxification/Crisis Stabilization
- ☐ Diagnostic Assessment
- ☐ Intensive In Home
- ☐ Mobile Crisis Management
- ☐ Multisystemic Therapy (MST)
- ☐ Non Hospital Detox
- ☐ Opioid Treatment
- ☐ Partial Hospital
- ☐ Professional Treatment Services in Facility Based Crisis Programs (FBCP)
- ☐ Psychosocial Rehab
- ☐ Substance Abuse (SA) Comprehensive Outpatient Treatment Program
- ☐ SA Intensive Outpatient Program
- ☐ SA Medically Monitored Community Residential Treatment
- ☐ SA Non Medical Community Residential Treatment

2. NPI Number: _____

3. Name of Agency: _____

Doing Business As (if applicable): _____

4. Physical (Site) Address: _____

_____
City State Zip code **+ 4 digits**

_____ 5. Mental Health License Number: MHL-_____-_____.
County (as reflected on license if applicable)

6. Mailing/Payment Address: _____

_____
City State Zip code **+ 4 digits**

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COMMUNITY INTERVENTION SERVICE (CIS) AGENCY RE-ENROLLMENT ADDENDUM

7. Telephone Number: (   ) _________ - ___________

8. Fax Number: (   ) _________ - ___________

9. E-mail Address: ____

10. Contact Person's Name: ____

11. Contact Person's Telephone Number: (   ) _________ - ___________ Extension ___________

12. List all shareholders/partners **(including yourself)** who have **5% or more ownership interest** AND all individual officers, directors, managers, and Electronic Funds Transfer (EFT) authorized individuals and information requested on each. In addition, Non-Profits should complete the fields below to identify the Board of Directors. Use an additional page if necessary. ***All questions must be answered. Failure to provide true and correct information, or providing information that is false or misleading shall be cause for denial or termination of participation as a Medicaid Provider. Federal law requires disclosure of the Social Security Number. DMA protects this information in accordance with privacy and confidentiality law.***

Name and Address	Title	SSN	% Owner
	Relationship to enrolling provider:		
	❑ Owner ❑ Shareholder ❑ Partner ❑ Board Member		
	❑ Spouse ❑ Parent ❑ Child ❑ Sibling ❑ Other		

Name and Address	Title	SSN	% Owner
	Relationship to enrolling provider:		
	❑ Owner ❑ Shareholder ❑ Partner ❑ Board Member		
	❑ Spouse ❑ Parent ❑ Child ❑ Sibling ❑ Other		

Name and Address	Title	SSN	% Owner
	Relationship to enrolling provider:		
	❑ Owner ❑ Shareholder ❑ Partner ❑ Board Member		
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Name and Address	Title	SSN	% Owner
	Relationship to enrolling provider:		
	❑ Owner ❑ Shareholder ❑ Partner ❑ Board Member		
	❑ Spouse ❑ Parent ❑ Child ❑ Sibling ❑ Other		

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COMMUNITY INTERVENTION SERVICE (CIS) AGENCY RE-ENROLLMENT ADDENDUM

13. Have you, or individuals or organizations having a direct or indirect ownership or controlling interest of five percent (5%) or more in this business been convicted of a criminal offense related to the involvement of such persons or organization in the programs of Medicaid (Title XIX) or Social Services Block Grant (XX)?
    Yes ❑ No ❑ (If you answered 'Yes', attach explanation)

14. Have any of your directors, officers, agents or managing employees of your group been convicted of a criminal offense related to their involvement in the program of Medicaid, Medicare or Social Services Block Grant?
    Yes ❑ No ❑ (If you answered 'Yes', attach explanation)

15. Have civil monetary penalties ever been levied by Medicare, Medicaid or other State or Federal Agency or Program against this or any corporations, businesses, agencies or facilities operated by any shareholders/partners listed in Item '12' on page two of this Addendum?
    Yes ❑ No ❑ (If you answered 'Yes', attach explanation)

16. Have civil monetary penalties ever been levied by Medicare, Medicaid or other State or Federal Agency or Program against any other corporation, business, agency or facility in which shareholders/partners listed in Item '12' on page two of this Addendum had 5% or more ownership interest including yourself, individual officers, directors or managers?
    Yes ❑ No ❑ (If you answered 'Yes', attach explanation)

17. Have you or any of the individuals listed in Item '12' on page two of this Addendum ever:

a. Been convicted of a felony, had adjudication withheld on a felony, pled no contest to a felony or entered into a pre-trial agreement for a felony?
   Yes ❑ No ❑

If yes, list the name(s) of the individual(s) and provide a copy of the administrative complaint and final disposition:

_____

_____

b. Had any disciplinary action taken against any business or professional license held in this or any other state? Or had your license to practice restricted, reduced or revoked in this or any other state?
   Yes ❑ No ❑

If 'Yes' to 'E b', complete below and attach a copy of the final disposition. Attach documentation from the proper authorities that approve the reinstatement of the license:

Against Whom?	Action Taken?	Who took Action?	Date of Action?

c. Been denied enrollment, been suspended or excluded from Medicare or Medicaid in any state, or been employed by a corporation, business, or professional association that has ever been suspended or excluded from Medicare or Medicaid in any state?
   Yes ❑ No ❑

If 'Yes', list the name(s) and provider number(s) of the individual(s) and provide a copy of the documentation:

Name	Medicaid Provider Number

Continued on next page

COMMUNITY INTERVENTION SERVICE (CIS) AGENCY RE-ENROLLMENT ADDENDUM

d. Had suspended payments from Medicare or Medicaid in any state, or been employed by a corporation, business, or professional association that had suspended payments from Medicare or Medicaid in any state?
Yes ❑ No ❑

e. Owes money to Medicaid or Medicare that has not been paid?
Yes ❑ No ❑ (If you answered 'Yes', attach explanation)

18. Is this organization, agency or business incorporated?
Yes ❑ No ❑
If yes, please attach a copy of the completed Application for Incorporation, complete copy of Certified Articles of Incorporation and complete copy of any subsequent changes to the Application/Articles of Incorporation.

19. In what specific counties of the state will the service(s) be provided?
_____

20. Is the agency, organization or individual provider(s) endorsed, licensed, certified, accredited, or approved by any professional organization or Board?
Yes ❑ No ❑
If yes, please attach copy of endorsement, license, certification, accreditation, permit, approval, etc.

21. **Signature of Owner(s) or Authorized Agent Required:**
I certify that the above information is true and correct. I further understand that any false or misleading information may be cause for denial or termination of participation as a Medicaid Provider.

_____ _____
Signature of Owner or Authorized Agent **Date**

_____
Printed Name and Title of person signing above

Providers: Do Not Write Below This Space

FOR INTERNAL USE BY THE DIVISION OF MEDICAL ASSISTANCE

EFFECTIVE DATE:
This agreement is executed and shall become effective on the _____ day of _____ in the year of _____.
The agreement shall remain subject to renewal on a periodic basis. A new agreement may be required as DMA necessitates, by operation of law, Medicaid regulations, polices or other material circumstances, or termination upon substitution of a new agreement, or by act of the parties as herein provided. You are herein authorized to provide services which are in accordance with the approved service definitions.

DMA APPROVAL:
Accepted on _____ by _____